IWK Perinatal Centre Referral/Request for Consultation

Main Phone: (902) 470-6445
Main Fax: (902) 470-7467

- **Please complete <u>all</u> fields. Incomplete referrals will be returned for completion.**
- **For MFM consultation for fetal assessment, please do <u>not</u> use this form. Please fill out & fax a referral to the IWK Fetal Assessment and Treatment Centre (FATC)**

Patient Name _____
DOB (yyyy/mon/dd) _____
Address _____

_____
Phone Number _____

Lived Name _____ Pronouns _____
Provincial HCN _____ Province _____
If no provincial insurance:
Non Canadian ☐ Yes ☐ No
Student/Permanent Resident ☐ Yes ☐ No
☐ Interpreter Required - language: _____

Referring Care Provider _____

Care provider phone number _____

Care provider fax number _____

Maternal Age _____

G__ T__ P__ A__ L__
Best estimate of EDD (yyyy/mon/dd) _____

Current gestational Age_____Weeks_____

Based on:
☐ IVF: day ___ embryo transfer date: _____
☐ LMP: _____ Certain/regular cycles? ☐Yes ☐No
☐ Dating ultrasound: fill in details below / attach report

Genetic screening/ testing completed:
MST ☐ Discussed ☐ Req. Given ☐ Declined
NIPS ☐ Discussed ☐ Completed
Amnio ☐ CVS ☐
Prenatal Screening ☐ Declined

Uncertain dates or irregular menstrual cycles, confirm that a dating ultrasound has been ordered Yes __No___

35 years or older at delivery:
Early Pregnancy Review offered Yes___ Req Sent ___ Declined___ Completed___

FATC Information: Fax request to FATC if not already done.
Fax: 902-470-7987 Phone: 902-470-2781

Indication(s) for Referral:
☐ Routine Prenatal Care – low risk provider
☐ Routine Prenatal Care – likely moderate or high risk
☐ Consult only for opinion and recommendations
☐ Consult with Possible Transfer of Care

Please outline specific concerns: Maternal or Fetal (Additional Pages Attached ☐ Yes ☐ No)

_____
_____
_____
_____
_____

In order to process the referral, the following documentation should be included with the faxed referral:

1. **Antenatal records ___**
2. **All relevant blood work____**
3. **Prenatal genetic screening results MST____ NIPS____**
4. **Ultrasound reports**

Date referral received: _____ Date referral triaged: _____	Patient to be seen: ☐ Within 1 week___ ☐ 2-3 weeks ___ ☐ 4-6 Weeks ___